



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box

Number 19

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Date Received

April 13, 2006

MFDR Tracking Number

M4-06-5310-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated April 25, 2006: "The carrier denied payment with payment exception codes 'W10', '50', '18', '97', and 'D20-150'. The carrier did not complete an on-site audit. The carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges...The applicable reimbursement methodology for the services provided to the injured worker in this matter is the Stop Loss Method found at §134.401 (c) (6) (A) (iii)."

Requestor's Supplemental Position Summary dated November 3, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request...in consideration of the Texas Third Court of Appeals' Final Judgment."

Amount in Dispute: \$193,901.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated May 17, 2006: "This medical dispute concerns Requestor's bill for an eight day inpatient stay in the amount of \$469,360.65. Requestor makes no claim that its services were 'unusually extensive; Requestor makes no claim that its services were 'unusually costly'. Requestor has not identified any treatment, service or procedure that was unusually costly and extensive."

Respondent's Supplemental Position Summary received September 9, 2011: "Requestor has failed to file a proper request for reconsideration with Respondent...Requestor contends that Respondent is required to make a reimbursement at 75% of audited charges for billed charges that reach the stop-loss threshold of \$40,000.00...Requestor, however, does not provide any information which demonstrates why the Stop-Loss Method would be applied and/or that the treatment/services provided for the disputed dates of service that were preauthorized were 'unusually extensive' and unusually costly'."

Above Responses submitted by: Law Offices of John D Pringle

Respondent's Post-Appeal Supplemental Response dated September 27, 2011: "...Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to

adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception...”

Post-Appeal Response Submitted by: Flahive, Ogden & Laughlin

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 2, 2005 through May 10, 2005	Inpatient Hospital Services	\$193,901.16	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. Former 28 Texas Administrative Code §133.301, effective July 15, 2000, provides for retrospective review of medical bills.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 97 – Payment included in the allowance for another service/procedure.
- Allowance reflects 75% of total billed charges.
- W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 18 – Duplicate claim/service.
- 50-Based upon a review of billed charges this appears to be an overcharge and/or excessive amount for services rendered.
- W12-Disallowed; services do not appear related to work injury/diagnosis. Recommended allowance is based on an Intracorp nurse review.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the

requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original medical dispute resolution (MDR) submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The documentation filed by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor in its position statement asserts that "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes." 28 Texas Administrative Code §133.304(c), amended effective July 15, 2000, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits was issued using the division-approved form TWCC 62 and noted reason codes "97, W10, 150, 50, W12, and 18".

Former 28 Texas Administrative Code §133.301 states "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." In reference to reason code "50", the requestor obtained preauthorization for a nine inpatient stay with preauthorization number PH215095A; therefore, this denial reason is not supported.

According to the explanation of benefits, the respondent denied unlisted special services code 99199 for \$2,348.00 based upon reason code "W12." The Accumulated Itemized Analysis report indicates that these charges are for a Private room. The Division finds that the "W12" reason code is not supported.

Payment exception codes and descriptions for "97, W10, 150 and 18" support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c) (6) (A) (i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c) (6) (A) (v); therefore the audited charges equal \$469,360.65. The division concludes that the total audited charges exceed \$40,000.
3. The requestor in its original position statement further asserts that "...if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). The rule does not require Vista to provide evidence that the service provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in

order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c) (2) (C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6) (A) (ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The requestor’s supplemental position statement asserts that:

“The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers’ compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay (‘LOS’) for workers’ compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed.”

The requestor’s categorization of spinal surgeries presumes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor’s position that all spinal surgeries are unusually extensive does not satisfy §134.401(c) (2) (C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals’ November 13, 2008 opinion affirmed this, stating “The rule further states that independent reimbursement under the Stop-Loss Exception will be ‘allowed on a case-by-case basis.’ *Id.* §134.401(c) (2) (C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor’s position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c) (2) (C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor’s supplemental position statement asserts that:

“The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers’ compensation inpatient surgeries is \$23,187; the median charge for workers’ compensation surgeries of this type is \$39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the \$40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery.”

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c) (6) (A) (i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor’s position that the admission is unusually costly based on the mere fact that the billed or audited charges “substantially” exceed \$40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the comparison surgeries. Therefore, the requestor fails to demonstrate that the hospital’s resources used in this particular admission are unusually costly when compared to the hospital’s resources used in other types of surgeries.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of

reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c) (1) titled *Standard Per Diem Amount* and §134.401(c) (4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c) (4) apply only to bills that do not reach the stop-loss threshold described in subsection (c) (6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c) (3) (ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was eight days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of eight days results in an allowable amount of \$8,944.00.
- 28 Texas Administrative Code §134.401(c) (4) (A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” Review of the requestor’s medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	Surgical fibriller	Surgical fibriller absorbale hemostat	2 @ \$72.00 ea	\$144.00	\$158.40
	Putty DBX	DBX Putty 5 cc	3 @ \$695.00	\$2,085.00	\$2,293.50
	Putty/paste DBX	DBX Putty 10cc	3 @ \$1072.00 ea	\$3,216.00	\$3,537.60
	Putty OP-1	Op-1 putty	5 @ \$5250.00 ea	\$26,250.00	\$28,875.00
	Rod Blackstone	450mm rod w/hex ends	2 @ \$495.00 ea	\$990.00	\$1089.00
	Optium putty	No support for cost/invoice	1	\$0.00	\$0.00
	Grafton flex 2.5x5	Grafton flex 2.5x5cm	2 @ \$799.00 ea	\$1598.00	\$1757.80
	Screw set Blackstone	Set screw	13 @ \$176.00 ea	\$2,288.00	\$2,516.80
	Cage TI-peek-ALIF	TI-peek-ALIF bone restructor	3 @ \$5795.00 ea	\$17,385.00	\$19,123.50
	Screw multi	Multi-axial screw	13 @ \$1469.00 ea	\$19,097.00	\$21,006.70
	Vista Lordotic	19x20mm Lordotic Vista	2 @ \$4155.00	\$8310.00	\$9141.00
			TOTAL ALLOWABLE \$89,499.30		

The division concludes that the total allowable for this admission is \$8,944.00 per diem plus \$89,499.30 carve-out allowable for a total of \$98,443.30. The respondent issued a total payment of \$158,119.33. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c) (1) titled *Standard Per Diem Amount*, and §134.401(c) (4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ 7/19/2013 Date
_____ Signature	_____ Director, Health Care Business Management	_____ 7/19/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.